DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Disability and Elder Services
DDE-987 (11/05)

AUTHORIZED REPRESENTATIVE DESIGNATION
MEDICAID COMMUNITY WAIVER PROGRAMS
Individualized Service Plan (ISP)

Instructions: It is preferable to have the applicant/recipient sign documents relating to the Medical Assistance Community Waiver Programs with either a signature or mark to indicate his/her expressed preferences. (Those persons experiencing cognitive difficulties should be evaluated to see if another method is more appropriate.) However, the applicant/recipient may designate someone to sign the ISP on his/her behalf by completing the following form. If signed by an "X" or other mark, this form must be witnessed by two persons. The designated authorized representative and/or the case manager may act as witnesses should the applicant/recipient sign by an "X."

I authorize _____ represent me and to act on my behalf and
(Print Full Name)
best interest in my application for the Medical Assistance Waiver Program. I have been consulted in the design of my service plan and my preferences are known to my representative.

_____ _____
SIGNATURE – Recipient / Applicant Today's Date

_____ _____
SIGNATURE – Witness Today's Date

_____ _____
SIGNATURE – Witness Today's Date

I agree to represent _____ in his/her application to the Medicaid
(Print Applicant's Name)
Waiver Program. I have consulted with him/her and know what kinds of services are needed or desired.

_____ _____
SIGNATURE – Authorized Representative Today's Date

_____ _____
SIGNATURE – Witness Today's Date